GOMB

KEY BUDGET DRIVER FRAMEWORK

Medicaid

Maintaining Utah's competitive edge and quality of life requires that we proactively manage and address the multiple demands being placed on limited resources—the taxpayer dollar. Utah's growing and changing population along with new dynamics in our revenue streams places an increased demand on everything from infrastructure to education and the state's natural resources to our correctional system. Reacting to new demands and changes within the economy without a proactive approach to budget design and strategy could potentially leave Utah vulnerable to a diminished future prosperity.

For Utah, there are six key elements that drive approximately 80 percent of expenditures: Corrections, Employee Compensation and Liabilities, Higher Education, Infrastructure (transportation, buildings, and debt), Medicaid, and Public Education. The ability to develop sound planning strategies and to resolve the challenges within these key areas is fundamental to a thriving economy. These planning strategies, or what we in GOMB refer to as ***key budget drivers****, have been developed in consultation with subject-matter experts and key stakeholders.*

Overview of Medicaid Budget Driver

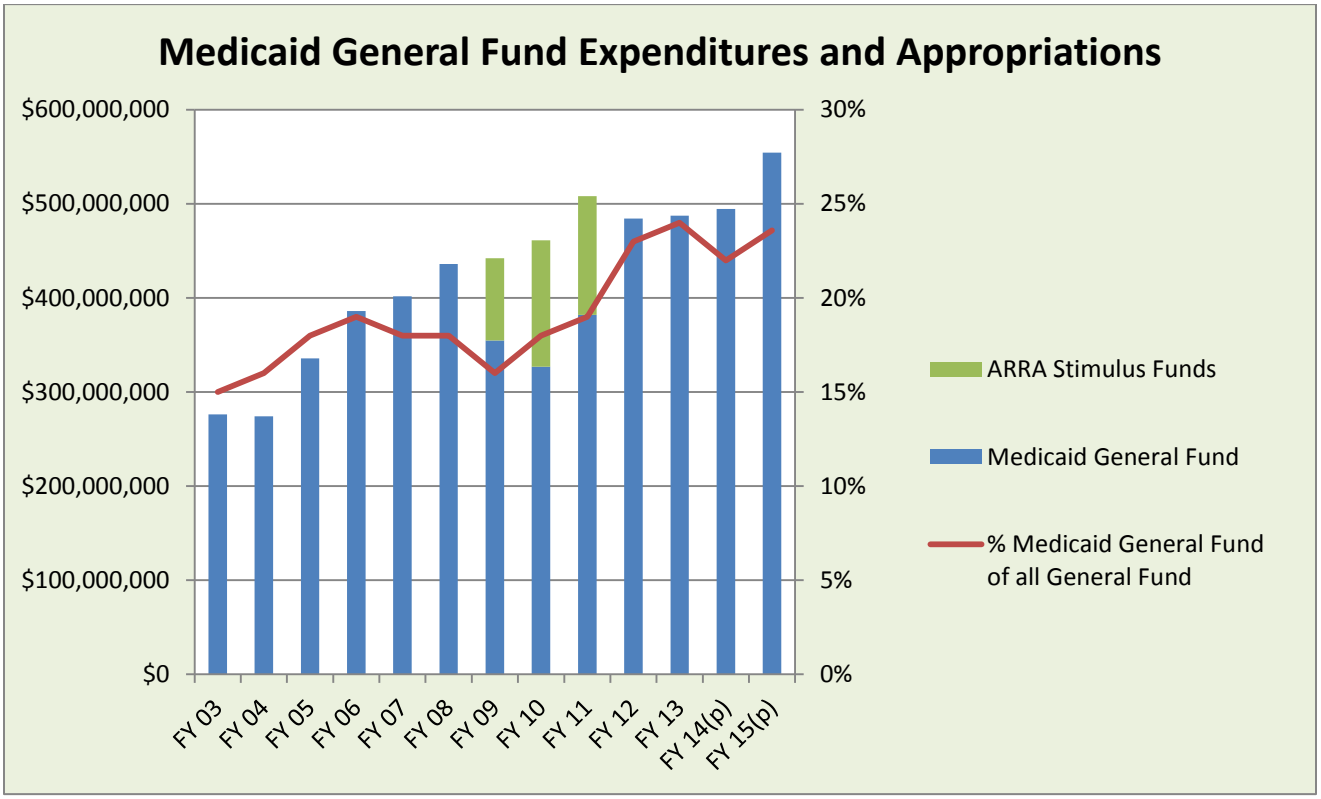
Utah's Medicaid program is a state and federal cooperatively funded entitlement program that provides health care services to nearly 300,000 [1] individuals throughout the state. Medicaid eligibility requirements vary by demographic, with qualified income thresholds reaching up to 133 percent of the Federal Poverty Level for some core service groups. In general, adults without dependent children do not qualify for Medicaid on the sole basis of low income and asset status.[2]

Medicaid's relevance as a primary budget driver relate to both the volume and growth trajectory of program expenditures. In 1993, Medicaid General Fund expenditures (after including an estimate for Medicaid expenditures made by non-Department of Health entities) accounted for approximately 12 percent of all State General Funds. By 2003, Medicaid expenditures comprised 15 percent of all State General Funds. In 2013, expenditures had grown to 24 percent of all State General Funds. Because of savings related to the expansion of a capitated provider payment structure, collections of erroneous Medicaid payments by the Medicaid Fraud Control Unit, Office of Inspector General and Office of Recovery Services, as well as an increase in pharmacy rebates, among savings from other sources, Fiscal Year 2014 Medicaid expenditures are expected to dip to 22 percent of all State General Funds. However, by Fiscal Year 2015, expenditures are expected to have resumed growth and are estimated to account for 23.5 percent of all State General Funds in that year.

Medicaid expenditures are naturally a function of enrollment levels and cost per enrollee. Current forecasts predict that by Fiscal Year 2015 the percentage of all Utahns receiving Medicaid will exceed 12 percent. If such projections hold, the percentage of Utah's population receiving Medicaid benefits will have doubled from the years 1993 to 2015.

[1] Average Medicaid Enrollment during Fiscal Year 2013 was 296,494, including enrollees on the Qualified Medicare Beneficiaries Program (QMB) and Primary Care Network (PCN). Enrollment figures include duplication in instances where one individual is receiving benefits through multiple aid groups

[2] Adults without dependent children may qualify for Medicaid if they meet program eligibility requirements for disability, blindness and age. They may also qualify under QMB or PCN.



Objectives of Medicaid Policy and Budget Decisions

Utah's Medicaid policies should aim to provide quality health insurance coverage at a long-run sustainable cost to an appropriate scope of the Utah public. The program should be structured in a fashion that aligns incentives between providers, insurers and patients so that optimal health, cost and societal outcomes are achieved.

Significant Issues, Potential Challenges and Risks

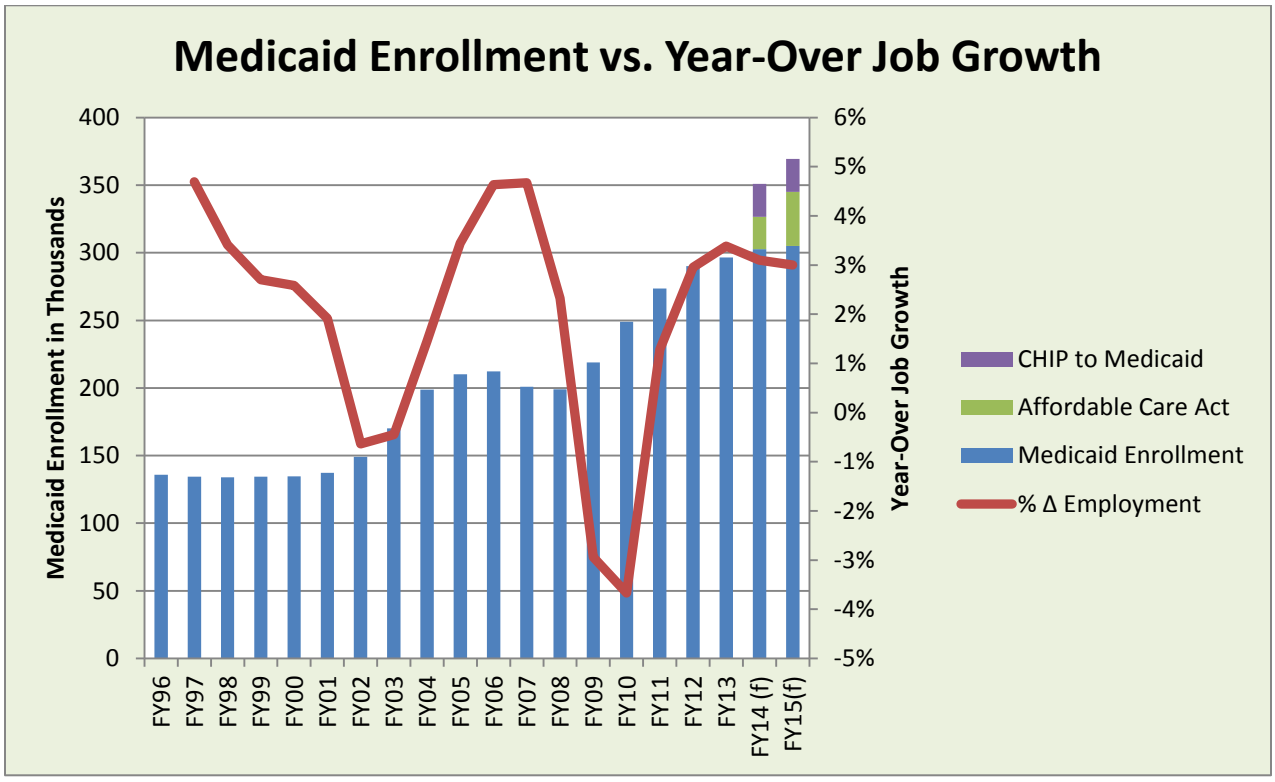
Numerous factors have shaped the current state of Medicaid expenditures, such as population growth and programmatic changes, but perhaps none more so than the economic climate of the previous decade. Medicaid possesses the qualities of an automatic stabilizer program in that enrollment levels tend to run counter cyclical to expansionary economic activity. As employment losses sourced to the recessions of the early and latter 2000s mounted, Medicaid roles expanded from 2002 – 2005 and 2009 – 2013.

Current Utah job growth projections for 2014 and 2015 are 3.1 and 3.0 percent, respectively[3]. Employment gains of this magnitude are expected to put downward pressure on Medicaid enrollment growth, yielding a marginal 0.9 percent increase in baseline enrollment in Fiscal Year 2015. However, program changes stemming from the 2010 Patient Protection and Affordable Care Act (ACA) are expected to cause significant increases in Medicaid enrollment in Fiscal Years 2014 and 2015. Along with numerous other provisions, the ACA mandates (with few exceptions) that all U.S. citizens carry health insurance. Additionally, the ACA removed the asset test from Medicaid eligibility standards and

[3] October 2013 State of Utah Revenue Assumptions Working Group

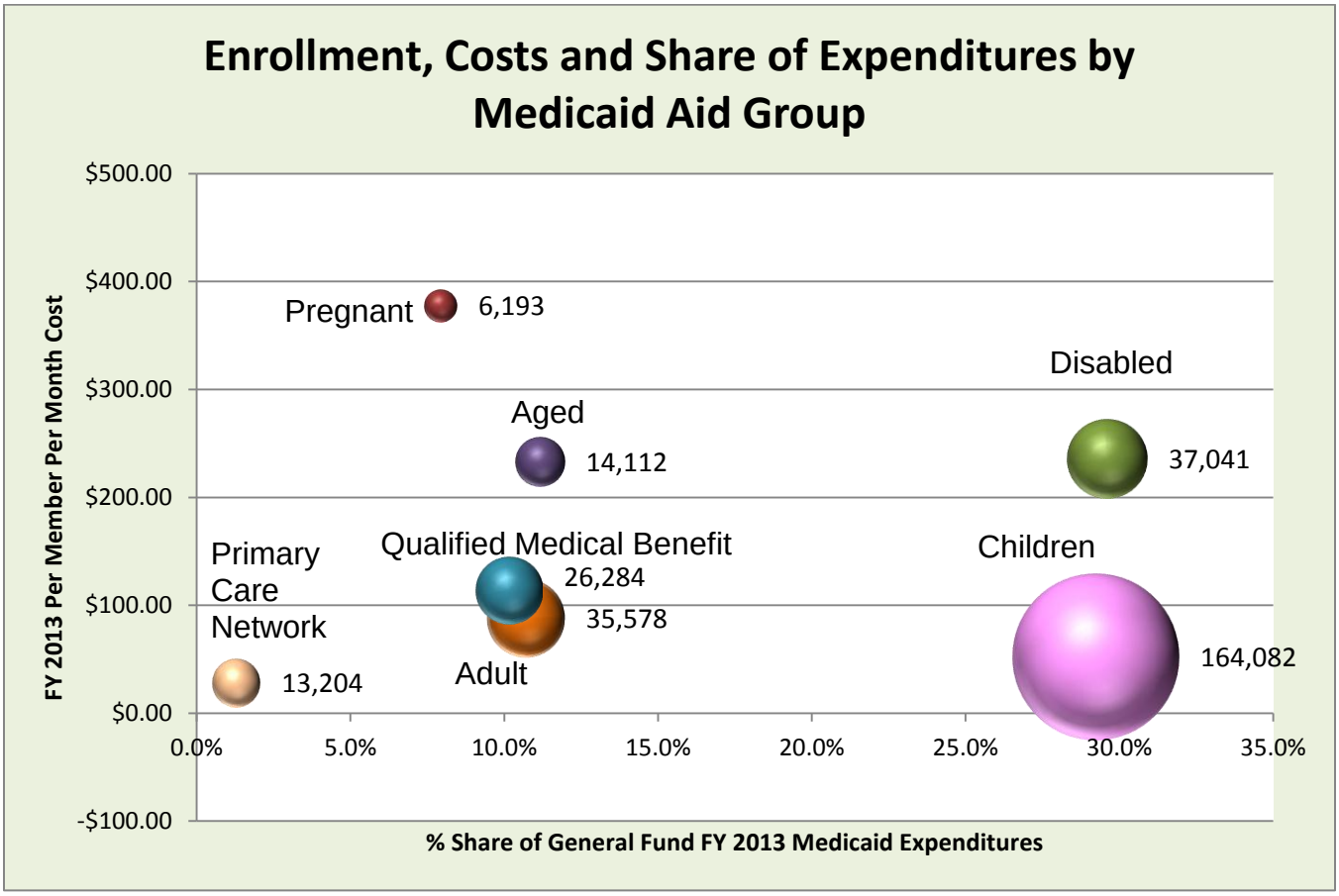
requires that children in households earning less than 138 percent of the Federal Poverty Level be eligible for Medicaid services. It is anticipated that these ACA provisions will add approximately 24,000 new program enrollees in FY 2014 (along with 24,271 Children's Health Insurance Program enrollees transferring to Medicaid) and an additional 16,000 new program enrollees in FY 2015. It is estimated that ACA-related enrollment increases will account for $10,022,200 in additional General Fund expenditures in FY 2014 and $33,407,600 in additional General Fund expenditures in FY 2015.

Under the ACA, states have the option of extending Medicaid services to adults without dependent children and to current Medicaid eligible populations with earnings up to 138 percent of the Federal Poverty Level. Utah has not made a Medicaid expansion determination at the time of publication. However, the ACA legislation as described above will change the landscape of Utah's uninsured, independent of whether the state elects to expand access to coverage. (See "Identifying Utah's Uninsured Adult Population").



In January of 2013, Utah reformed Medicaid's payment structure through the large-scale adoption of Accountable Care Organizations as central Medicaid providers. Utah's Accountable Care Organizations (Molina Healthcare, Select Health, University of Utah Healthy U and HealthChoice Utah) receive capitated reimbursements for services provided to Medicaid beneficiaries. A capitated payment environment gives providers incentive to deliver quality healthcare efficiently and at the lowest cost. The ACOs cover all Medicaid enrollees in urban Utah (Salt Lake, Davis, Utah and Weber counties). Total ACO coverage accounts for more than 70 percent of the state's Medicaid enrollment. Current estimates of cost savings connected to the ACO structure are $3,000,000 - $4,000,000 in FY 2013. However, greater savings are anticipated as ACO operations accelerate in the coming years and cost

mitigation opportunities are secured in high-cost patient groups, such as Disabled, and high-share-of expenditure groups, such as Children.



Guiding Principles for Medicaid Budget and Policy Decisions

Neoclassical economic theory posits that people behave as utility maximizing economic agents who engage in rational decision-making when allocating their time and resources. In aggregate, this behavior shapes the market structure under which our economy functions. However, it is also accepted that market failures exist and that some individuals' circumstances are such that the provision of societal safety nets are warranted. Even so, public benefit programs should be designed in a fashion that does not undermine the incentive arrangements central to free market economies. This can be achieved via the inclusion of requirements of effort (participation requirements) for able-bodied adults in program policy rules. Conversely, the Federal Centers for Medicare and Medicaid Services (CMS) has sought to frame Medicaid as an entitlement-only program and has historically blocked Utah's attempts at incorporating participation requirements in some waiver-based Medicaid programs. This 'no strings attached' policy approach differentiates Medicaid from numerous other public benefit programs (Temporary Assistance for Needy Families, Food Stamps, Unemployment Insurance, etc.) that require benefit recipients to engage in efforts towards self-sufficiency. Participation requirements with appropriate exemptions could help to define the scope of public healthcare benefits in a manner that extends services to those with serious or acute healthcare needs, transitions those with short-term needs to self-sufficiency, and excludes those who possess less costly and more practical alternatives to

healthcare than taxpayer subsidized benefits. Such requirements would become particularly relevant under a Medicaid expansion scenario, as nondisabled adults without dependent children would gain program eligibility as a core service group.

While including participation provisions in Medicaid eligibility rules would capitalize on economic fundamentals and assist in appropriately focusing the scope of benefit access, there are potential challenges involved unique to the healthcare arena. As participation policies are developed, the following should be considered:

- Medical Needs Fluctuate. Some Medicaid recipients suffer from chronic illness and follow a predictable treatment schedule, whereas other Medicaid beneficiaries experience needs that fluctuate during times of wellness and episodes of illness. Medicaid participation requirements should account for this dichotomy by including rules that prevent individuals from only meeting participation during times of medical need. Open enrollment sessions, exclusionary periods or 'make-up' participation opportunities could help to discourage this behavior, if allowed by CMS.

- Not all Cost Sharing is Equal. Patient cost sharing includes premiums, copays and deductibles, among other forms of payments. These payments help to ration healthcare, like all goods and services, by compelling the consumer to internalize a portion of the costs of insurance and/or treatment. Conversely, excessive cost sharing (even in the form of sanctions for nonparticipant beneficiaries) could disincentivize some from addressing health concerns while their condition is in an early and relatively inexpensive stage to treat, ultimately leading to greater healthcare utilization than what would have otherwise been the case. It is because of this phenomenon that variable cost sharing should be reduced or forgone for preventative and value-based treatments, and imposed or increased on preference-sensitive procedures. With regard to fixed cost sharing, such as monthly premiums, differential rates could be assessed and adjusted to incentivize participation adherence.

- Positive Employment Outcomes Can Produce Net-Loss Situations. As Medicaid enrollees find and secure employment opportunities, they may increase their household income levels and/or gain employer-provided health insurance coverage. Unfortunately, some individual experiences may be such that a small incremental increase in household income could result in Medicaid ineligibility. In other instances, employer-provided coverage may be less rich than Medicaid benefits in terms of provider network, costs and allowable procedures. Under these scenarios, program policy could be bolstered or written so that premium subsidies (such as those granted under the Utah's Premium Partnership program) and wrap-around Medicaid benefits are granted to those who become employed but remain in or near poverty.

It is important to remember that a certain percentage of the uninsured face barriers to participation such as lack of transportation, poor work-readiness and serious health conditions. Participation exemptions should be formulated and scaled so that access to Medicaid services is preserved for those who need it most. Finally, previously mentioned supply-side Medicaid reforms such as capitated payments for providers and preferred drug list pricing also represent guiding principles for Medicaid policy and budget decisions.

Areas Requiring Additional Research and Consideration

Courses of action under which Utah Medicaid policy objectives can be achieved are numerous. Provider reforms, such as the operation of Accountable Care Organizations, could potentially be expanded beyond the Wasatch Front to less populated Metropolitan Statistical Areas such as Cache and Washington counties. Demand-side reforms such as participation requirements, open enrollment, increased cost sharing and state-granted premium subsidies could also be implemented, but would likely require approval from the Federal Centers for Medicare and Medicaid Services. It will also be necessary to determine the costs of funding various options for partial or full Medicaid expansion along with corresponding policy implications as compared to no expansion.